MGMA
Medical Group Management Association
Connecticut

Statement concerning

Senate Bill 433 – An Act Concerning Standards and Requirements for Health Carriers' Provider Networks and Contracts between Health Carriers and Participating Providers

Insurance and Real Estate Committee
March 15, 2016

This statement is being submitted on behalf of the Connecticut Medical Group Management Association concerning Senate Bill 433 – An Act Concerning Standards and Requirements for Health Carriers' Provider Networks and Contracts between Health Carriers and Participating Providers. As part of our profession, we have seen a dramatic shift in health care over the past few years. The Affordable Care Act has increased the amount of patients with health care insurance. It has also increased the number of plans in the market. The increase of plans and products in the market has inexplicably led to a very limited and narrow tiers of provider networks which make it very difficult for patients to determine which physicians they have access to. In addition, physician offices are often unable to accurately and confidently identify for patients, the networks in which insurers consider physicians networked providers. As practice managers, we are often on the front lines communicating with patients in this very frustrating process of determining a networked provider.

We understand that specialty medical societies and the Connecticut State Medical Societies have submitted testimony with their concerns with this bill and we share those concerns. We agree with them in that network adequacy must be measured by the number of physicians who are actually practicing in Connecticut and who are able to examine and provide care to a patient. It is simply insufficient to include physicians who are only available via telemedicine. As other groups have already noted, given the infancy of telemedicine and telehealth, any reference to it should be removed from the bill. Maintaining an adequate network should also mean that health care plans should not reduce the number of network providers without sufficient notice. The bill before you would allow a health carrier to reduce 24% of its providers before notifying the Commissioner. Reducing providers by this amount would significantly restrict access to a great number of patients.

We also support other medical societies and associations in their concerns with the contracting standards portion of this bill. While we appreciate that this committee recognizes that there needs to be standards in contracting between insurers and physicians, several portions of the bill are overly burdensome to physicians. Language in the bill puts the burden of nonpayment of claims or expenses on physicians; requires that physicians provide free medical care during a health carrier's insolvency despite an insolvency fund; allows health carriers to put restrictions on services which a participating provider will be responsible for rather than letting this be dictated by statutory scope pf practice; and obligates the physician, when receiving a letter of removal from a health carrier, to providing the health carrier with a "list of such participating provider's patients who are covered persons under a network plan of such health carrier" even though the carrier has easier access to that information.

We hope that this committee will consider modifying the bill in both the network adequacy portion and the standards in contracting portion.

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